Filing at a Glance

Company:	TIAA-CREF Life Insurance Company
Product Name:	2020 Conversion Application Filing
State:	District of Columbia
TOI:	L04I Individual Life - Term
Sub-TOI:	L04I.500 Other
Filing Type:	Form
Date Submitted:	02/13/2020
SERFF Tr Num:	TCRE-132160095
SERFF Status:	Submitted to State
State Tr Num:	
State Status:	
Co Tr Num:	F10700.4
Implementation Date Requested:	On Approval
Author(s):	Karen Casale, Linda Hester
Reviewer(s):	
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: District of Columbia **Filing Company:** TIAA-CREF Life Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.500 Other
Product Name: 2020 Conversion Application Filing
Project Name/Number: F10700.4/F10700.4

General Information

Project Name: F10700.4
Project Number: F10700.4
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Linda Hester

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 02/13/2020
State Status Changed:
Created By: Linda Hester
Corresponding Filing Tracking Number:

Filing Description:

We are enclosing for your review and approval a copy of our TIAA-CREF Life Insurance Company Term Insurance Conversion Application, form Number F10700.4 and Form Number TCL-F9764.1, Amendment to Application.

Form number F10700.4 replaces our form number F10700.3 previously approved by your department on 09/22/2017 under SERFF Tr Num: TCRE-131166328.

Form Number TCL-F9764.1, is the Amendment to Application that will be used. This form replaces Form Number TCL-F9764, previously approved by your department on Disposition Date: 05/15/2000.

We are updating the attached application forms. Form No. F10700.4 has been updated to remove any reference to any product other than the Flexible Premium Universal Life Insurance product. We have also included a redlined version of these forms to show what changes have been made to the previously approved forms.

Pending your approval, we intend to provide form number F10700.4 and form number TCL-F9764.1 to our Individual life insurance policyholders who may wish to exercise their conversion option under their TIAA-CREF Life Insurance Term policy to the TIAA-CREF Life permanent life insurance, Flexible Premium Universal Life Insurance policy.

The Flexible Premium Universal Life Insurance policy that is referenced above was recently approved by your department on 10/04/2019 under SERFF Tracking No. TCRE-132028714.

Extension of Use:

We intend to use the following policy forms, previously approved by your Department, with policy form numbers F10700.4 and TCL-F9764.1

Waiver of Monthly Charges Rider AM-SVWMC.2
Policy Endorsement POLPAGE-END
Aviation Limitation Endorsement AM-VAL.1
Charitable Benefit Rider, TCL-CHAREDUC.2
Overloan Endorsement, AM-OVERLOAN.1 (2008)

We intend to begin using the attached forms as soon as possible after receiving your approval.

For your review, we have bracketed the variable text of the forms. The issued application and amendment will not contain

variable language. The forms referenced in this letter will be computer generated with the identical language approved by your Department. TIAA-CREF Life Insurance Company reserves the right to change duplex printing, line location of sentences and words, signature graphics, and the type font (but not the point size) of the forms without resubmitting them for approval.

Thank you for your cooperation

Company and Contact

Filing Contact Information

Linda Hester, Contract Forms Specialist
730 Third Avenue
New York, NY 10017

Linda.Hester@tiaa.org
800-842-2733 [Phone] 295005 [Ext]

Filing Company Information

TIAA-CREF Life Insurance Company
730 Third Avenue
New York, NY 10017
(212) 490-9000 ext. [Phone]

CoCode: 60142
Group Code: 1216
Group Name: TIAA-CREF
FEIN Number: 13-3917848

State of Domicile: New York
Company Type: L&H
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

SERFF Tracking #:	*TCRE-132160095*	***State Tracking #:***		***Company Tracking #:***	*F10700.4*

State:	*District of Columbia*	***Filing Company:***	*TIAA-CREF Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.500 Other*		
Product Name:	*2020 Conversion Application Filing*		
Project Name/Number:	*F10700.4/F10700.4*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		APPLICATION FOR TERM CONVERSION	F10700.4	AEF	Revised	*Previous Filing Number:*	*TCRE-131166328*	49.700	F10700.4.pdf
						Replaced Form Number:	*F10700.3*		
2		Amendment to Application	TCL-F9764.1	AEF	Revised	*Previous Filing Number:*	*Disposition Date: 05/15/2000*	46.100	TCL-F9764.1.pdf
						Replaced Form Number:	*TCL-F9764*		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

TIAA-CREF LIFE INSURANCE COMPANY
Policy Owner Services Administrative Office [P.O. Box 724508, Atlanta, GA 31139]
Home Office [730 Third Avenue, New York, NY 10017-3206]
Toll-Free [877-694-0305]

Please Print in Black or Blue Ink

APPLICATION FOR CONVERSION - TERM TO INTELLIGENT LIFE UNIVERSAL LIFE INSURANCE

SECTION A: Policy Change Election and Information

Existing Coverage to be Converted

Term Policy No. _____

Base Face Amount $ _____

Cost-of-Living Face Amount $ _____

Total Face Amount $ _____

If you are not converting the full face amount, please confirm the balance of the Original Policy to be continued:

$_____
(must meet the minimum face amount shown in my policy)

New Universal Life Insurance Coverage

Face Amount $ _____
(the face amount of the new policy cannot be less than $100,000 or greater than the face amount of the original policy)

Initial Premium $ _____

SECTION B: Insured Information

1. Full Legal Name of Insured (First/Middle/Last) _____

2. Gender ☐ M ☐ F **3.** Social Security No. _____ **4.** Date of Birth (mm/dd/yyyy) _____

5. Primary Telephone No. _____ Alternate Telephone No. _____

6. Email Address _____

7. Preferred Method of Contact ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.

8. Residential Street Address _____

City _____ State _____ Zip _____

9. Mailing Address ☐ Same as Residential Address _____

City _____ State _____ Zip _____

10. Birthplace State _____ Country _____

11. Are you a U.S. Citizen? ☐ Yes ☐ No *(If "Yes," Skip to Question 12)*

If "No," Country of Citizenship _____

Are you a permanent U.S. Resident that holds a permanent visa? ☐ Yes ☐ No

a. Visa Number _____ b. Visa Type _____

c. Visa Expiration Date _____

12. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership

SECTION C: Primary Owner Information

COMPLETE THIS SECTION ONLY IF THE OWNER IS DIFFERENT FROM THE INSURED.

☐ Other Person ☐ Trust ☐ Business or Corporation

IF AN INDIVIDUAL OWNS THIS POLICY, COMPLETE THIS SECTION.

1. Full Legal Name of Owner (First/Middle/Last) _____
2. Gender ☐ M ☐ F 3. Social Security No. _____ 4. Date of Birth (mm/dd/yyyy) _____
5. Primary Telephone No. _____ Alternate Telephone No. _____
6. Email Address _____
7. Preferred Method of Contact ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.
8. Residential Street Address _____
   City _____ State _____ Zip _____
9. Mailing Address ☐ Same as Residential Address _____
   City _____ State _____ Zip _____
10. Birthplace State _____ Country _____
11. Are you a U.S. Citizen? ☐ Yes ☐ No *(If "Yes," Skip to Question 12)*
    If "No," Country of Citizenship _____
    Are you a permanent U.S. Resident that holds a permanent visa? ☐ Yes ☐ No
    a. Visa Number _____ b. Visa Type _____
    c. Visa Expiration Date _____
12. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership

IF A TRUST OWNS THIS POLICY, COMPLETE THIS SECTION.

1. Full Name of Trust _____
2. Date of Trust (mm/dd/yyyy) _____ 3. Trust Taxpayer Identification No. _____
4. Name of Primary Trustee _____
   Additional Trustee(s) _____
5. Primary Telephone No. _____ Alternate Telephone No. _____
6. Email Address _____
7. Preferred Method of Contact ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.
8. Mailing Address _____
   City _____ State _____ Zip _____

IF A BUSINESS OR CORPORATION OWNS THIS POLICY, COMPLETE THIS SECTION.

1. Name of Business or Corporation _____
2. Business Taxpayer Identification No. _____
3. Name of Corporate Officer and Title _____
4. Primary Telephone No. _____ Alternate Telephone No. _____
5. Email Address _____
6. Preferred Method of Contact ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.
7. Mailing Address _____
   City _____ State _____ Zip _____

SECTION D: Policy Endorsements, Options and Riders

1. Death Benefit Option (If unanswered, Option A will be applied)

   ☐ Option A - Level..... benefit equals face amount

   ☐ Option B - Increasing ..... benefit equals face amount plus policy cash value

   ☐ Option C - Face Amount + Premium.. benefit equals face amount plus premium(s) paid

2. Definition of Life Insurance Test ☐ Guideline Premium Test ☐ Cash Value Accumulation Test
   - If unanswered, the Guideline Premium Test will be applied. This election cannot be changed after issue.

3. Overloan Protection Endorsement ☐ Yes ☐ No
   - Cannot elect "Yes" if the Waiver of Monthly Charges Rider or Cash Value Accumulation Test is elected.
   - If unanswered, and neither the Waiver of Monthly Charges Rider or Cash Value Accumulation Test is elected, this endorsement will be added.
   - There is no monthly charge to add this endorsement to the Policy. However, if this Policy becomes Overloaned, at that time the Policy value will be reduced to equal the outstanding loan.

4. Waiver of Monthly Charges ☐ Yes ☐ No
   - Only available if the existing coverage being converted includes the Waiver of Premium Rider.
   - The Insured must be between the ages of 18 and 60 years old, if continuing the coverage.
   - Cannot be elected "Yes" if Overloan Protection Endorsement is elected "Yes."

5. Charitable Giving Benefit Rider
   - There is no additional cost for this rider.
   - Will automatically be included if existing coverage being converted includes the Charitable Giving Benefit Rider or Institutional Charitable Benefit Rider.
   - The designated beneficiary will be carried over from the existing coverage being converted to the Universal Life policy and may be changed according to the terms of the Rider.

SECTION E: Premium Payment Information

Please complete this section as it will be used for the billing of future premiums. The initial premium payment is due with your completed conversion application.

1. **PAYMENT FREQUENCY** - Premiums shall be made payable:

☐ Lump Sum in the amount of $ _____

☐ Planned Annual Premium $ _____

How do you want to pay your premiums?

☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly (EFT only)

2. **PAYMENT METHOD**

☐ Check

☐ Electronic Funds Transfer (EFT) - EFT is not available for the initial premium.

☐ Option A - Use my existing EFT account on file for my life insurance policy (include Name of Financial Institution and last 4 digits of account number in the space below); **U.S. Financial Institutions only.**

☐ Option B - If the account is not on file, attach an original voided check or savings deposit slip (it must display your financial institution's routing number and your account number); **U.S. Financial Institutions only**.

To authorize payment by EFT, you must provide the following information:

Account Type ☐ Checking ☐ Savings

Financial Institution Routing No.* _____ Account No. _____

*Refer to the bottom of your check or savings deposit slip for the 9-digit routing number.

Name(s) on the Account _____

Financial Institution Name _____

Address _____

City _____ State _____ Zip _____

Telephone No. _____

SECTION F: Third-Party Notification - Protection Against Unintended Lapse in Coverage

Although the election of this option only authorizes TIAA-CREF Life Insurance Company to send an additional notice to a designated third party advising that the policy is in danger of lapse, it does not mean that the third party is responsible for preventing such a lapse. In addition, certain circumstances and provisions in the policy may govern procedure, thereby preventing the policy from any kind of lapse.

1. I elect to have an additional notice regarding any lapse in premium payment sent to a third party of my choosing. ☐ Yes ☐ No
   If "Yes," please provide Name and Residential Address below.
2. Full Legal Name
   (Title, First, Middle, Last, Suffix) _____
3. Residential Street Address _____
   City _____ State _____ Zip _____
4. Telephone No. _____ 5. Email Address _____

SECTION G: Beneficiary Information

It is important that your beneficiary designation be clear so that there will be no question as to your intent as to what each beneficiary will receive upon the death of the Insured. It is also important that you name a primary and contingent beneficiary. If more than one primary or contingent beneficiary is named without a percentage indicated, the proceeds will be divided equally. **If percentages are indicated, the total of the percentages in each beneficiary class must equal 100%.**

Note: If a class includes more than one person, the proceeds are divided equally among the living beneficiaries of the class. For example, if you name more than one Primary Beneficiary (Class I) and one of them predeceases the Insured, that Beneficiary's share is divided equally among the surviving Primary Beneficiaries. If no Primary Beneficiary (Class I) is living at the time of Insured's death, the proceeds are payable to the contingent beneficiary(ies) (Class II).

PAYMENT TO CHILDREN OF A DECEASED BENEFICIARY (Per Stirpes[1]) Example: If a primary or contingent beneficiary predeceases the Insured, the amount he or she would have received will be paid in equal amounts to the surviving children of the primary or contingent beneficiary(ies). By indicating Yes or No, this provides that should the beneficiary predecease the Insured, the share percentage allotted to the deceased beneficiary will pass in equal shares to the first generation of the deceased beneficiary's living lineal descendants, which may be his or her children or grandchildren.

If more space is needed, an additional sheet may be attached and must be signed and dated by the Owner(s).

PRIMARY BENEFICIARY(IES) - PLEASE PRINT

1. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | Date of Birth or Date of Trust

Address | City/ST/Zip | Country of Residence

Telephone Number | Benefit % | Relationship | Per Stirpes ☐ Yes ☐ No

2. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | Date of Birth or Date of Trust

Address | City/ST/Zip | Country of Residence

Telephone Number | Benefit % | Relationship | Per Stirpes ☐ Yes ☐ No

Total benefit % must equal 100%

CONTINGENT BENEFICIARY(IES) - PLEASE PRINT

1. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | Date of Birth or Date of Trust

Address | City/ST/Zip | Country of Residence

Telephone Number | Benefit % | Relationship | Per Stirpes ☐ Yes ☐ No

2. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | Date of Birth or Date of Trust

Address | City/ST/Zip | Country of Residence

Telephone Number | Benefit % | Relationship | Per Stirpes ☐ Yes ☐ No

Total benefit % must equal 100%

[1] Unless you state otherwise in the table above, the term "Per Stirpes" includes individuals legally adopted or born before and after the signature date of this application and who are members of the class on the date of your death. Please consult your estate planning attorney prior to making any Per Stirpes designation. TIAA-CREF Life Insurance Company does not, and cannot, provide you with legal advice. The right to change beneficiaries is reserved to the Owner.

Continued on the next page

SECTION G: Beneficiary Information (Continued)

If you live, or have formerly lived, in a state subject to community property laws and you do not designate your spouse, domestic partner or civil union partner as the sole primary beneficiary, you understand that TIAA Life will not assume responsibility for determining whether your life insurance policy(s) is/are subject to community property laws.

Spousal, Domestic Partner or Civil Union Partner Consent and Waiver - If the Owner and the Owner's spouse, domestic partner or civil union partner lives, or formerly lived, in one of the community property states listed below and if the Owner's spouse, domestic partner or civil union partner is not designated as the beneficiary for at least 50% of the death proceeds of the policy, the Owner's spouse, domestic partner or civil union partner should sign the consent and waiver. ([Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin].)

I, the undersigned spouse, domestic partner or civil union partner, consent to the beneficiary designation of any person or entity to receive the death proceeds from the above identified policy, and to the use of community property to contribute additional premiums to this policy. I understand and intend that this consent and waiver relinquishes any and all interest I may have in the ownership and proceeds of this policy, and any community property used to contribute additional premiums. This consent and waiver is effective as of the date it is signed.

NOTE: This consent and waiver does not affect my right to receive proceeds or income from the proceeds if I am named as a beneficiary of this policy or of a trust that owns this policy. (Signature must be witnessed and certified by a Notary Public if Spouse, Domestic Partner or Civil Union Partner is signing off on this document.)

_____ _____

Printed Name and Signature of Spouse, Domestic Partner or Civil Union Partner — Today's Date

NOTARY PUBLIC CERTIFICATION

STATE OF _____

COUNTY OF _____ } SS:

ACKNOWLEDGMENT

On this _____ day of _____, 20_____, before me, the undersigned notary public, personally appeared _____(name of document signer) proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is signed on this page, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

IN WITNESS WHEREOF, I have set my hand and seal the day and year as above written.

WITNESS my hand and official seal

_____

(Notary signature)

_____

Notary Public (Notary's printed or typed name)

My Commission Expires: _____

(Official Seal)

SECTION H: Fraud Warning

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim for insurance benefits containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to criminal penalties, including confinement in prison, and civil penalties. Such action may entitle the insurance company to deny or void coverage or benefits.

Alabama residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska residents, please note: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona residents, please note: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Rhode Island and West Virginia residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California residents, please note: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado residents, please note: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware residents, please note: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida residents, please note: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho residents, please note: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana residents, please note: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Maine residents, please note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

Minnesota residents, please note: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire residents, please note: Any person who with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Mexico residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio residents, please note: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma residents, please note: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Continued on the next page

SECTION H: Fraud Warning (Continued)

Oregon residents, please note: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania residents, please note: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas residents, please note: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont residents, please note: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to the penalties under state law.

Washington residents, please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SECTION I: Application Authorization

ACKNOWLEDGEMENTS

I understand that any change will not be effective unless and until TIAA-CREF Life Insurance Company (a) received all premiums and any other amounts due; (b) approves the conversion.

I understand that any waiver of the Company's rights or requirements or modification of any contract will bind TIAA-CREF Life Insurance Company only if it is in writing and signed by the President or a duly authorized officer of the company.

To the best of my knowledge and belief, all of the answers contained herein are true and complete. This application will be attached to and made a part of the issued policy.

A

X _____ _____ _____

Printed Name and Signature of Insured | Signed at (City and State) | Date

B

X _____ _____ _____

Printed Name and Signature of Primary Owner | Signed at (City and State) | Date

C

X _____ _____ _____

Printed Name and Signature of Primary Trustee/Corporate Officer | Signed at (City and State) | Date

Additional Owner/Trustee/Corporate Officer Signatures

X _____ _____ _____

Printed Name | Title | Signature | Signed at (City and State) | Date

X _____ _____ _____

Printed Name | Title | Signature | Signed at (City and State) | Date

Continued on the next page

Additional Signature(s) - If needed, attach a separate signed and dated copy of this page with the form.

SECTION I: Application Authorization (Continued)

Signatures Requiring Notary Certification
If a Power of Attorney, Collateral Assignee and/or Irrevocable Beneficiary are signing this document, signatures must be witnessed and certified by a Notary Public.

D Any Power of Attorney(s) on record must sign and date below if signing on behalf of another person.

I, _____ as Power of Attorney, am signing on behalf of _____.

X _____ _____ _____
Printed Name and Signature of Power of Attorney | Signed at (City and State) | Date

E Any Collateral Assignee(s) on record must sign and date below.

X _____ _____ _____
Printed Name and Signature of Collateral Assignee | Signed at (City and State) | Date

X _____ _____ _____
Printed Name and Signature of Collateral Assignee | Signed at (City and State) | Date

F Any Irrevocable Beneficiary(ies) on record must sign and date below acknowledging the new beneficiary designation.

X _____ _____ _____
Printed Name and Signature of Irrevocable Beneficiary | Signed at (City and State) | Date

X _____ _____ _____
Printed Name and Signature of Irrevocable Beneficiary | Signed at (City and State) | Date

NOTARY PUBLIC CERTIFICATION

STATE OF _____
COUNTY OF _____ } SS:

ACKNOWLEDGMENT

On this _____ day of _____, 20_____, before me, the undersigned notary public, personally appeared _____(name of document signer) proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is signed on this page, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

IN WITNESS WHEREOF, I have set my hand and seal the day and year as above written.

WITNESS my hand and official seal

_____
(Notary signature)

_____
Notary Public (Notary's printed or typed name)

My Commission Expires: _____

(Official Seal)

Additional Signature(s) - If needed, attach a separate signed, notarized (where applicable), and dated copy of this page with the form.

SECTION J: Mailing Instructions

Please return your completed application to our administrative office at:

STANDARD MAIL:
TIAA
[P.O. Box 724508]
[Atlanta, GA 31139]

OVERNIGHT MAIL:
TIAA
[3225 Cumberland Blvd SE, Suite 700]
[Atlanta, GA 30339]

Please call us toll-free at **877-694-0305**, Monday - Friday from 8 a.m. to 6 p.m. (ET) if you would like any assistance in completing this conversion application.

TIAA-CREF LIFE INSURANCE COMPANY
Administrative Office: [P.O. Box 724508, Atlanta, GA 31139]
Home Office: [730 Third Avenue, New York, NY 10017-3206]

Amendment to Conversion Application

Insured: _____ Term Policy No. _____

Owner: _____

The application for Intelligent Life Universal Life insurance signed on _____ is hereby amended to reflect the following:

PLEASE REVIEW AND/OR COMPLETE THE AMENDED ITEM(S) BELOW

Section	Field	Amended Item(s)
[_____]	[_____]	[_____]

VERIFY THE AMENDED INFORMATION ABOVE BY SIGNING AND DATING BELOW. RETURN TO US IN THE ENCLOSED ENVELOPE.

To the best of my knowledge and belief, all of the statements substituted above as answers to corresponding questions in the amended application are true and complete. I understand and agree this Amendment, together with my conversion application, constitutes the entire application and will be the basis of and become part of any policy issued. I acknowledge that TIAA-CREF Life Insurance Company will rely upon the information provided herein, and that the statements and answers I have provided are given to TIAA-CREF Life Insurance Company as consideration for issuing the insurance for which I have applied.

_____
Signature of Insured Date

_____
Signature of Owner/Trustee/Corporate Officer/Authorized Party Date

_____
Signature of Collateral Assignee (if applicable) Date

_____
Signature of Irrevocable Beneficiary (if applicable) Date

Additional Signature(s) - If needed, attach a separate signed and dated copy of this page.

SERFF Tracking #:	*TCRE-132160095*	***State Tracking #:***		***Company Tracking #:***	*F10700.4*

State:	*District of Columbia*	***Filing Company:***	*TIAA-CREF Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.500 Other*		
Product Name:	*2020 Conversion Application Filing*		
Project Name/Number:	*F10700.4/F10700.4*		

Supporting Document Schedules

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	SOV Final TIAA Life Term Conversion App F10700.4 (004).pdf SOV Final TIAA Life Term Conversion Amendment_TCL_F9764.1.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Redlined Versions
Comments:	
Attachment(s):	F10700.4 Redline.pdf TCLF9764 Redline.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Generic Readability Certification.pdf
Item Status:	
Status Date:	

TIAA-CREF Life Insurance Company

Memorandum of Variable Material for the following Application:

Form No. F10700.4

January 31, 2020

Page (s)	Section	Provision	Range of Values
1	HEADER	LOGO	The LOGO in use at time of issue date.
1	HEADER	Policy Owner Services Administrative Office: Insurance Service Center, P.O. Box 724508, Atlanta, GA 31139 (877) 694-0305	The name, address and telephone number of our administrative office as of issue date.
1	HEADER	Home Office: 730 Third Avenue, New York, NY 10017-3206	The name and address of our home office as of issue date.
6	SECTION G	Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin	States will either be added or removed depending upon state regulations.
9	INSTRUCTIONS SECTION J	Insurance Service Center, P.O. Box 724508, Atlanta GA 31139 877-694-0305 Overnight Mail Address 3225 Cumberland Blvd SE, Suite 700 Atlanta, GA 30339	The name, address and telephone number of our insurance service center as of issue date.
1-9	FOOTER	TIUNC	The Work Process ID (WPID) is a series of numbers assigned and is used during the indexing stage in the Imaging Services area to direct it to the correct area in the insurance workflow system. The elements of the WPID determine the business area and the type of transaction that the document represents.

TIAA-CREF Life Insurance Company

Memorandum of Variable Material for the following
Amendment to Conversion Application:

Form No. TCL-F9764.1

January 31, 2020

Page	Section	Provision	Range of Values
1	HEADER	LOGO	The LOGO in use at time of issue date.
1	HEADER	Administrative Office: P.O. Box 724508, Atlanta, GA 31139	The name and address of our administrative office as of issue date.
1	HEADER	Home Office: 730 Third Avenue, New York, NY 10017-	The name and address of our home office as of issue date.
1	SECTION	Sections of the Application that had missing or incorrect answers and need to be amended	Section(s) A – Policy Change Election and Information B – Insured Information C – Primary Owner Information D – Policy Endorsements, Options, Riders E – Premium Payment Information G – Beneficiary Information
1	FIELD	Field in Section A of the Conversion Application that had missing or incorrect answers that need to	Section A – Policy Change Election and Information Face Amount
1	FIELD	Fields in Section B of the Conversion Application that had missing or incorrect answers that need to be amended	Section B – Insured Information Full Legal Name Gender Social Security Number Date of Birth Residential Street Address including City, State, Zip Mailing Address including City, State, Zip US Citizen question

1	FIELD	Fields in Section C of the Conversion Application that had missing or incorrect answers that need to be amended	Section C – Primary Owner Information Full Legal Name Gender Social Security Number Date of Birth Owner/Trust Residential Street Address including City, State, Zip Owner/Trust Mailing Address including City, State, Zip US Citizen question Owner/Trust Tax ID Number Trust Details Trust Date Business or Corporation Details
1	FIELD	Fields in Section D of the Conversion Application that had missing or incorrect answers	Section D – Policy Endorsements, Options, Riders Death Benefit Option Definition of Life Insurance Test Overloan Protection Endorsement Waiver of Monthly Charges
1	FIELD	Fields in Section E of the Conversion Application that had missing or incorrect answers	Section E – Premium Payment Information Payment Frequency Payment Method
1	FIELD	Fields in Section G of the Conversion Application that had missing or incorrect answers	Section G – Beneficiary Information Beneficiary Name or Trustee Beneficiary Relationship Beneficiary Percentage Beneficiary Date of Birth Beneficiary Primary or Contingent selection
1	FOOTER	TIUNC	The Work Process ID (WPID) is a series of numbers assigned and is used during the indexing stage in the Imaging Services area to direct it to the correct area in the insurance workflow system. The elements of the WPID determine the business area and the type of transaction that the document represents.

TIAA-CREF LIFE INSURANCE COMPANY
Policy Owner Services Administrative Office: P.O. Box 724508, Atlanta, GA 31139
Home Office: 730 Third Avenue, New York, NY 10017-3206
Toll Free: 877-694-0305

Please Print in Black or Blue Ink

APPLICATION FOR ~~TERM~~ CONVERSION – TERM TO INTELLIGENT LIFE UNIVERSAL LIFE INSURANCE

SECTION A: Policy Change Elections and Information

Existing Coverage to be Converted:

Term Policy No.: _____

Base ~~Coverage~~ Face Amount: $ _____

Cost-of-Living ~~Coverage~~ Face Amount: $_____

Total ~~Coverage~~ Face Amount: $ _____

~~Balance of Original Policy is to be:~~

☐ ~~Continued~~ ☐ ~~Terminated~~

If you are not ~~going to~~ converting the full face amount, please confirm the balance of the Original Policy to be continued:

$_____

(~~Must~~ must meet the minimum face amount shown in my policy)

New ~~Coverage Being Converted to~~ Universal Life Insurance Coverage:

~~Select Policy Type - Permanent Insurance Options:~~

☐ ~~Universal Life~~ ☐ ~~Variable Universal Life~~

Face Amount: $_____

~~Must be equal to the current face amount, or less (minimum face amount = $100,000)~~ (the face amount of the new policy cannot be less than $100,000 or greater than the face amount of the original policy)

Initial Premium: $_____

~~Planned Annual Premium: $_____~~

SECTION B: Insured Information

1. Full Legal Name of Insured (First/Middle/Last) _____
~~Full Legal Name of Insured~~

2. Gender: ☐ M ☐ F 3. Social Security No.: _____ 4. Date of Birth (mm/dd/yyyy) _____
~~MM/DD/YYYY~~

5. Primary Telephone No.: _____ Alternate Telephone No.: _____

6. Email ~~address~~Address: _____

7. Preferred Method of Contact: ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.

8. Residential ~~address~~ Street Address: _____ ~~Apt. No.:~~ _____

City: _____ State: _____ Zip: _____

9. Mailing ~~address~~Address: ☐ Same as Residential Address _____ ~~Apt. No.:~~ _____

City: _____ State: _____ Zip: _____

10. Birthplace State Country _____

~~10.~~11. Are you a ~~United States~~U.S. Citizen? ☐ Yes ☐ No (If "Yes," ~~Proceed~~ Skip to Question ~~No. 11~~12): ~~:~~

If "No," ~~are you in possession of: Permanent Residency Card~~Country of Citizenship~~?~~ _____

Are you a permanent U.S. Resident that holds a permanent visa? ☐ Yes ☐ No ~~United States Visa? ■ Yes ■ No~~

~~Residency Card or~~ a. Visa ~~No~~Number.: _____ ~~Expiration Date~~b. Visa Type: _____

~~Number of years in United States~~ c. Visa Expiration Date _____ ~~:~~

~~11. Birthplace: State Country~~ _____

12. Marital Status: ☐ Single ☐ Married ☐ ~~Separated~~ ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership

SECTION C: Primary Owner Information ~~(Complete this Section only if the Owner is different from the Insured)~~

COMPLETE THIS SECTION ONLY IF THE OWNER IS DIFFERENT FROM THE INSURED.

☐ Other Person ☐ Trust ☐ Business or Corporation

IF AN INDIVIDUAL OWNS THIS POLICY, COMPLETE THIS SECTION.

1. Full Legal Name of Owner (First/Middle/Last) _____
~~Full Legal Name of Owner~~

2. Gender~~:~~ ☐ M ☐ F 3. Social Security No.~~:~~ _____ 4. Date of Birth~~:~~ (mm/dd/yyyy) _____ ~~:~~ ~~MM/DD/YYYY~~

5. Primary Telephone No.~~:~~ _____ Alternate Telephone No.~~:~~ _____

6. Email ~~address~~Address~~:~~ _____

7. Preferred Method of Contact~~:~~ ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.

8. Residential Street A~~a~~ddress~~:~~ _____ ~~Apt. No.:~~ _____

City~~:~~ _____ State~~:~~ _____ Zip~~:~~ _____

9. Mailing ~~address~~Address~~:~~ ☐ Same as Residential Address _____ ~~Apt. No.:~~ _____

City~~:~~ _____ State~~:~~ _____ Zip~~:~~ _____

10. Birthplace State _____ Country _____

~~10.~~11. Are you a ~~United~~ U.S. ~~States~~ Citizen? ☐ Yes ☐ No (If "Yes," Skip to Question 12) ~~Proceed to Question No. 11):~~

If "No," Country of Citizenship ~~are you in possession of: Permanent Residency Card?~~ _____

Are you a permanent U.S. Resident that holds a permanent visa? ☐ Yes ☐ No

a. Visa Number _____ b. Visa Type _____

c. Visa Expiration Date _____ ~~Yes ■ No United States Visa? ■ Yes ■ No~~

~~Residency Card or Visa No.:~~ _____ ~~Expiration Date:~~ _____

~~Number of years in United States:~~ _____ ~~11. Birthplace: State~~ _____ ~~Country~~ _____

12. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership

IF A TRUST OWNS THIS POLICY, COMPLETE THIS SECTION.

1. Full Name of Trust~~:~~ _____

2. Date of Trust (mm/dd/yyyy) _____ 3. Trust Taxpayer Identification No. _____

~~2.~~4. Name of Primary Trustee~~:~~ _____

Additional Trustee(s)~~:~~ _____

~~3.~~5. Primary Telephone No.~~:~~ _____ Alternate Telephone No.~~:~~ _____

~~4.~~6. Email ~~address~~Address~~:~~ _____

~~5.~~7. Preferred Method of Contact~~:~~ ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.

~~6.~~8. Mailing address~~:~~ _____ ~~Apt. No.:~~ _____

City~~:~~ _____ State~~:~~ _____ Zip~~:~~ _____

~~Trust Taxpayer Identification No.:~~ _____ 8. ~~Date of Trust:~~ ~~MM/DD/YYYY~~

~~NOTE: The Trustee Declaration of Authority Form must also be completed if converting to a Variable Universal Life.~~

IF A BUSINESS OR CORPORATION OWNS THIS POLICY, COMPLETE THIS SECTION.

1. Name of Business or Corporation~~:~~ _____

~~1.~~2. Business Taxpayer Identification No.~~:~~ _____

~~2.~~3. Name of Corporate Officer and Title~~:~~ _____

~~3. Corporate Officer Title:~~ _____

~~2.~~4. Primary Telephone No.~~:~~ _____ Alternate Telephone No.~~:~~ _____

~~4.~~5. Email address~~:~~ _____

~~5.~~6. Preferred Method of Contact~~:~~ ☐ Email ☐ Primary Telephone No. ☐ Alternate Telephone No.

~~6.~~7. Mailing address~~:~~ _____ ~~Apt. No.:~~ _____

City~~:~~ _____ State~~:~~ _____ Zip~~:~~ _____

~~7.~~ _____

~~NOTE: Additional documents may be required if converting to a Variable Universal Life.~~

SECTION D: Policy ~~Provisions, Options~~ Endorsements, Options and Riders

~~POLICY Provisions and OPTIONS~~

1. Death Benefit Option (If unanswered, Option A will be applied):
   - ☐ Option A – Level .....~~(~~benefit equals face amount~~)~~
   - ☐ Option B – Increasing .....~~(~~benefit equals face amount plus policy cash value~~)~~
   - ☐ Option C - Face Amount + Premium .....~~(~~benefit equals face amount plus premium(s) paid~~)~~

2. Definition of Life Insurance Test: ☐ Guideline Premium Test ☐ Cash Value Accumulation Test
   - ~~(~~If unanswered, the Guideline Premium Test will be applied.~~)~~ This election cannot be changed after issue.

~~3. Insurance Cost Options (If unanswered, the Traditional Age-Based cost will apply):~~
~~Traditional Age-Based 10-Year Level Endorsement 20-Year Level Endorsement~~

3. Overloan Protection Endorsement ☐ Yes ☐ No
   - Cannot elect "Yes" if the Waiver of Monthly Charges Rider or Cash Value Accumulation Test is elected.
   - If unanswered, and neither the Waiver of Monthly Charges Rider or Cash Value Accumulation Test is elected, this endorsement will be added.
   - There is no monthly charge to add this endorsement to the Policy. However, if this Policy becomes Overloaned, at that time the Policy value will be reduced to equal the outstanding loan.

4. Waiver of Monthly Charges ☐ Yes ☐ No
   - Only available if the existing coverage being converted includes the Waiver of Premium Rider.
   - The Insured must be between the ages of 18 and 60 years old, if continuing the coverage.
   - Cannot be elected "Yes" if Overloan Protection Endorsement is elected "Yes."

~~4.~~

5. Charitable Giving Benefit Rider
   - There is no additional cost for this rider.
   - Will automatically be included if existing coverage being converted includes the Charitable Giving Benefit Rider or Institutional Charitable Benefit Rider.
   - The designated beneficiary will be carried over from the existing coverage being converted to the Universal Life policy and may be changed according to the terms of the Rider.

~~5. Waiver of Monthly Charges: Yes No (Subject to underwriting review if this rider is newly added)~~
~~Cannot be elected "Yes" if Overloan Protection Endorsement is elected "Yes."~~

~~6. Overloan Protection Endorsement: Yes No~~
~~(If unanswered, this endorsement will be added. Cannot elect "Yes" if the Waiver of Monthly Charges Rider or Cash Value Accumulation Test is elected "Yes.")~~
~~There is no monthly charge to add this endorsement to the Policy. However, if this Policy becomes Overloaned, at that time the Policy value will be reduced to equal the outstanding loan.~~

~~CHARITABLE GIVING BENEFIT RIDER~~

~~The Charitable Giving Benefit Rider pays, upon the death of the insured, an additional death benefit, over and above the base policy death benefit, equal to one percent (1%) of the base policy's face amount. The additional benefit can be no greater than $100,000. The rider must be elected at or before policy issue and cannot be added after the date of policy issue. The designated beneficiary of this rider must be an institution accredited as a charity with the IRS under section 501(c)(3). TIAA-CREF Life Insurance Company will pay the institution in the name of the deceased insured. The costs and benefits of this rider are paid in their entirety by TIAA-CREF Life Insurance Company. Regardless of whether the policy owner elects or declines this optional rider, there is no additional cost. (This rider may not be available in all states.)~~

~~1. Charitable Giving Benefit Rider: ☐ Yes ☐ No~~
~~This rider cannot be added after issue.~~
~~2. Name of Qualified Institution: _____~~
~~3. Mailing Address: _____~~
~~City: _____ State: _____ Zip Code: _____~~
~~Telephone No.: _____ Tax ID No.: _____~~

SECTION ~~F~~E: Premium Payment Information

Please complete this section as it will be used for the billing of future premiums. ~~You will receive a notice for the initial premium as it is not required during the application review process.~~ The initial premium payment is due with your completed conversion application.

1. PAYMENT FREQUENCY - Premiums shall be made payable:

☐ Lump Sum in the amount of $ _____

☐ Planned Annual Premium: $ _____

How do you want to pay your premiums?

☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly (EFT only)

~~Lump Sum in the amount of $ _____ Planned Annual Premium: $_____~~

~~2. PAYMENT METHOD - How do you want to pay your premiums?~~

~~3.~~2. PAYMENT METHOD

☐ Check

☐ Electronic Funds Transfer (EFT) - EFT is not available for the initial premium.

☐ Option A: Use my existing EFT account on file for my life insurance policy (include Name of Financial Institution and last 4 digits of account number in the space below); **U.S. Financial Institutions only**.

☐ Option B: If the account is not on file, attach an original voided check or savings deposit slip (it must display your financial institution's routing number and your account number); **U.S. Financial Institutions only**.

~~Attach your voided check or savings deposit slip.~~

To authorize payment by EFT, you must provide the following information~~:~~

Account Type~~:~~ ☐ Checking ☐ Savings

~~Bank Transit~~ Financial Institution Routing No.*~~:~~ _____ ~~Bank~~ Account No.~~:~~ _____

*Refer to the bottom of your check or savings deposit slip for the 9-digit ~~bank transit~~ routing number.

Name(s) on Account _____

~~Name and Address of Bank~~ Financial Institution Name _____

Address _____

City _____ State _____ Zip _____

Telephone No. _____

SECTION ~~G~~F: Third-Party Notification - Protection Against Unintended Lapse in Coverage

Although the election of this option only authorizes TIAA-CREF Life Insurance Company to send an additional notice to a designated third party advising that the policy is in danger of lapse, it does not mean that the third party is responsible for preventing such a lapse. In addition, certain circumstances and provisions in the policy may govern procedure, thereby preventing the policy from any kind of lapse.

1. I elect to have an additional notice regarding any lapse in premium payment sent to a third party of my choosing. If "Yes," please provide Name and Residential Address below.	☐ Yes	☐ No
2. Full Legal Name (Title, First, Middle, Last, Suffix)~~:~~		
3. Residential Street Address~~:~~		~~Apt. No.:~~
City~~:~~	State~~:~~	Zip ~~Code:~~
4. Telephone No.~~:~~	5. Email Address~~:~~	

SECTION ~~E~~G: Beneficiary Information

It is important that your beneficiary designation be clear so that there will be no question as to your intent as to what each beneficiary will receive upon the death of the Insured. It is also important that you name a primary and contingent beneficiary. If more than one primary or contingent beneficiary is named without a percentage indicated, the proceeds will be divided equally. **If percentages are indicated, the total of the percentages in each beneficiary class must equal 100%.**

Note: If a class includes more than one person, the proceeds are divided equally among the living beneficiaries of the class. For example, if you name more than one Primary Beneficiary (Class I) and one of them predeceases the Insured, that Beneficiary's share is divided equally among the surviving Primary Beneficiaries. If no Primary Beneficiary (Class I) is living at the time of Insured's death, the proceeds are payable to the contingent beneficiary(ies) (Class II). ~~If you check yes to Lineal Descendants Per Stirpes[1] (LDPS) and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary, their portion will be paid proportionately to the remaining beneficiaries in that class.~~

PAYMENT TO CHILDREN OF A DECEASED BENEFICIARY (Per Stirpes[1]) Example: If a primary or contingent beneficiary predeceases the Insured, the amount he or she would have received will be paid in equal amounts to the surviving children of the primary or contingent beneficiary(ies). By indicating Yes or No, this provides that should the beneficiary predecease the Insured, the share percentage allotted to the deceased beneficiary will pass in equal shares to the first generation of the deceased beneficiary's living lineal descendants, which may be his or her children or grandchildren.

If more space is needed, an additional sheet may be attached and should be signed and dated by the Owner.

PRIMARY BENEFICIARY(IES) - PLEASE PRINT

1. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | ~~MM/DD/YYYY~~ Date of Birth or Date of Trust

Address | City/ST/Zip | (Country of Residence)

Telephone Number | ~~Relationship to Insured(s)~~ Benefit % | ~~Benefit %~~ Relationship | Per Stirpes ~~LDPS[2]:~~ Yes No ~~Irrevocable?: Yes No~~

2. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | ~~MM/DD/YYYY~~ Date of Birth or Date of Trust

Address | City/ST/Zip | (Country of Residence)

Telephone Number | ~~Relationship to Insured(s)~~ Benefit % | ~~Benefit %~~ Relationship | Per Stirpes ~~LDPS[2]:~~ Yes No ~~Irrevocable?: Yes No~~

Total benefit % must equal 100%

CONTINGENT BENEFICIARY(IES) - PLEASE PRINT

1. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | ~~MM/DD/YYYY~~ Date of Birth or Date of Trust

Address | City/ST/Zip | (Country of Residence)

Telephone Number | ~~Relationship to Insured(s)~~ Benefit % | ~~Benefit %~~ Relationship | Per Stirpes ~~LDPS[2]:~~ Yes No ~~Irrevocable?: Yes No~~

2. Full Legal Name of Beneficiary or Trust and Trustee(s) | Social Security No. or Tax ID No. | ~~MM/DD/YYYY~~ Date of Birth or Date of Trust

Address | City/ST/Zip | (Country of Residence)

Telephone Number | Benefit % | Relationship ~~to Insured(s)~~ | ~~Benefit %~~ | ~~Irrevocable?: Yes No~~ Per Stirpes ~~LDPS[2]:~~ Yes No

Total benefit % must equal 100%

[1]Unless you state otherwise in the table above, the term "Descendants" includes individuals legally adopted or born before and after the signature date of this application and who are members of the class on the date of your death. Please consult your estate planning attorney prior to making any ~~LDPS~~ Per Stirpes designation. TIAA-CREF Life Insurance Company does not, and cannot, provide you with legal advice. The right to change beneficiaries is reserved to the Owner.

~~[2] Lineal Descendants Per Stirpes - Indicate "Yes" or "No." If unanswered, it will be assumed the LDPS option does not apply to the associated beneficiary.~~

Continued on the next page

SECTION ~~E~~G: Beneficiary Information (Continued)

If you live, or have formerly lived, in a state with community property statutes and you do not designate your spouse, domestic partner or civil union partner as the sole primary beneficiary, you understand that TIAA Life will not assume responsibility for determining whether your life insurance policy(s) is/are subject to community property laws.

Spousal, Domestic Partner or Civil Union Partner Consent and Waiver ~~–~~ If the Owner and the Owner's spouse, domestic partner or civil union partner ~~currently reside~~lives, or formerly ~~resided~~lived, in one of the community property states listed below and if the Owner's spouse, domestic partner or civil union partner ~~spouse of the owner~~ is not designated as the beneficiary for at least 50% of the death proceeds of the policy, the Owner's spouse, domestic partner or civil union partner should sign the consent and waiver. (Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington ~~or~~and Wisconsin~~).~~)

I, the undersigned spouse, domestic partner or civil union partner, consent to the beneficiary designation of any person or entity to receive the death proceeds from the above identified policy, and to the use of community property to contribute additional premiums to this policy. I understand and intend that this consent and waiver relinquishes any and all interest I may have in the ownership and proceeds of this policy, and any community property used to contribute additional premiums. This consent and waiver is effective as of the date it is signed.

NOTE: This consent and waiver does not affect my right to receive proceeds or income from the proceeds if I am named as a beneficiary of this policy or of a trust that owns this policy. (Signature must be witnessed and certified by a Notary Public if Spouse, Domestic Partner or Civil Union Partner is signing off on this document.)

Printed Name and Signature of Spouse, Domestic Partner or Civil Union Partner _____ Today's Date _____

~~PLEASE PRINT Name of Spouse, Domestic Partner or Civil Union Partner~~ ~~Signature of Spouse, Domestic Partner or Civil Union Partner~~ ~~Date~~

~~PLEASE PRINT Name of Witness~~ ~~Signature of Witness~~ ~~Date~~

~~(Signature must be witnessed by someone other than a designated or potential beneficiary.)~~

NOTARY PUBLIC CERTIFICATION

STATE OF _____

COUNTY OF _____ } SS:

ACKNOWLEDGMENT

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer) proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is signed on this page, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

IN WITNESS WHEREOF, I have set my hand and seal the day and year as above written.

WITNESS my hand and official seal

_____

(Notary signature)

_____

Notary Public (Notary's printed or typed name)

(Official Seal) My Commission Expires: _____

~~SECTION H: Mailing Instructions~~

~~PLEASE RETURN YOUR COMPLETED APPLICATION TO OUR ADMINISTRATIVE OFFICE AT:~~

~~TIAA-CREF Life Insurance Company~~

~~P.O. Box 724508 Atlanta, GA 31139~~

~~Please call us toll-free at 877-694-0305, Monday - Friday from 8 a.m. to 6 p.m. (ET) if you would like any assistance in completing this conversion application.~~

SECTION ~~I~~H: ~~Application Authorization~~Fraud Warning

~~GENERAL FRAUD WARNING~~

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim for insurance benefits containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to criminal penalties, including confinement in prison, and civil penalties. Such action may entitle the insurance company to deny or void coverage or benefits.

Alabama residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska residents, please note: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona residents, please note: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Rhode Island and West Virginia residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California residents, please note: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado residents, please note: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Continued on the next page

SECTION ~~I~~H: ~~Application Authorization~~ Fraud Warning (Continued)

~~**FRAUD WARNING (Continued)**~~

Delaware residents, please note: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

~~Washington, DC~~District of Columbia residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. ~~WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.~~

Florida residents, please note: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho residents, please note: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana residents, please note: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Maine residents, please note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

Minnesota residents, please note: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire residents, please note: Any person who with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Mexico residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio residents, please note: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma residents, please note: ~~WARNING:~~ Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon residents, please note: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania residents, please note: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas residents, please note: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont residents, please note: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to the penalties under state law.

Washington residents, please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SECTION I: Application Authorization ~~(Continued)~~

~~CUSTOMER IDENTIFICATION NOTICE~~

~~To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who makes an Application. This means we will ask you for your name, address, date of birth and other information that will allow us to identify you. We may ask to see your driver's license or other identifying documents.~~

~~I acknowledge I have read the Customer Identification Notice. I understand that the identity information being provided by me is required by Federal law to be collected in order to verify my identity and I authorize its use for this purpose.~~

ACKNOWLEDGEMENTS

I understand that any change will not be effective unless and until TIAA-CREF Life Insurance Company (a) received all premiums and any other amounts due; (b) approves the conversion.

I understand that any waiver of the Company's rights or requirements or modification of any contract will bind TIAA-CREF Life Insurance Company only if it is in writing and signed by the President or a duly authorized officer of the company.

To the best of my knowledge and belief, all of the answers contained herein are true and complete. This application will be attached to and made a part of the issued policy.

A

X _____ _____ _____

Printed Name and Signature of Insured ~~or Authorized Person~~ | Signed at (City and State) | Date

B

X _____ _____ _____

Printed Name and Signature of Primary Owner ~~or Authorized Person~~ | Signed at (City and State) | Date

C

X _____ _____ _____

Printed Name and Signature of Primary Trustee~~-~~/~~-~~Corporate Officer | Signed at (City and State) | Date

Additional Owner~~-~~/ Trustee~~-~~/~~-~~Corporate Officer Signatures~~:~~

X _____ _____

Printed Name | Title | Signature | Signed at (City and State) | Date

X _____ _____

Printed Name | Title | Signature | Signed at (City and State) | Date

~~If more space is needed, an additional sheet may be attached and should be signed and dated by the Owner(s), Trustee(s) or Corporate Officer(s).~~

Continued on the next page

Additional Signature(s) – If needed, attach a separate signed and dated copy of this page with the form.

SECTION I: Application Authorization (Continued)

Signatures Requiring Notary Certification

If a Power of Attorney, Collateral Assignee and/or Irrevocable Beneficiary are signing this document, signatures must be witnessed and certified by a Notary Public.

☐ D **Any Power of Attorney(s) on record must sign and date below if signing on behalf of another person.**

I, _____ as Power of Attorney, am signing on behalf of _____.

X _____ _____ _____

Printed Name and Signature of Power of Attorney | Signed at (City and State) | Date

☐ ~~D~~E Any Collateral Assignee(s) on record must sign and date below.

X _____ _____ _____

Printed Name and Signature of Collateral Assignee | Signed at (City and State) | Date

X _____ _____ _____

Printed Name and Signature of Collateral Assignee | Signed at (City and State) | Date

☐ ~~E~~F Any Irrevocable Beneficiary(ies) on record must sign and date below acknowledging the new beneficiary designation.

X _____ _____ _____

Printed Name and Signature of Irrevocable Beneficiary | Signed at (City and State) | Date

X _____ _____ _____

Printed Name and Signature of Irrevocable Beneficiary | Signed at (City and State) | Date

NOTARY PUBLIC CERTIFICATION

STATE OF _____

COUNTY OF _____ } SS:

ACKNOWLEDGMENT

On this _____ day of _____, 20 _____, before me, the undersigned notary public, personally appeared _____ (name of document signer) proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is signed on this page, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

IN WITNESS WHEREOF, I have set my hand and seal the day and year as above written.

WITNESS my hand and official seal

_____

(Notary signature)

_____

Notary Public (Notary's printed or typed name)

(Official Seal) My Commission Expires _____:

Additional Signature(s) – If needed, attach a separate signed and dated copy of this page with the form.

SECTION J: Mailing Instructions

PLEASE RETURN YOUR COMPLETED APPLICATION TO OUR ADMINISTRATIVE OFFICE AT:

STANDARD MAIL:	OVERNIGHT MAIL:
TIAA	TIAA
P.O. Box 724508	3225 Cumberland Blvd SE, Suite 700
Atlanta, GA 31139	Atlanta, GA 30339

Please call us toll-free at 877-694-0305, Monday - Friday from 8 a.m. to 6 p.m. (ET) if you would like any assistance in completing this conversion application.

~~TIAA-CREF Life Insurance Company~~
~~730 Third Avenue~~
~~New York, NY [10017-3206]~~
~~[212-490-9000] [1-800-223-1200]~~

TIAA-CREF LIFE INSURANCE COMPANY
Administrative Office: [P.O. Box 724508, Atlanta, GA 31139]
Home Office: [730 Third Avenue, New York, NY 10017-3206]

Amendment ~~To~~to Conversion Application

~~Proposed Insured _____ File No.~~
~~(Please print full name)~~

~~I wish to amend Part I / Part II of my~~
Insured: _____ Term Policy No. _____

Owner: _____

The application for ~~life~~Intelligent Life Universal Life insurance signed on _____ ~~as follows:~~
~~(circle one) Month Day Year~~ _____ is hereby amended to reflect the following:

~~FOR ALL AYES@ ANSWERS YOU PROVIDE, PLEASE EXPLAIN IN DETAIL BELOW.~~

PLEASE ~~TURN~~REVIEW AND/OR COMPLETE THE ~~PAGE OVER~~AMENDED ITEM(S) BELOW

Section	Field	Amended Item(s)
[_____]	[_____]	[_____]

VERIFY THE AMENDED INFORMATION ABOVE BY SIGNING AND DATING BELOW. RETURN TO US IN THE ENCLOSED ENVELOPE.

To the best of my knowledge and belief, all of the statements substituted above as answers to corresponding questions in the amended application ~~amended~~ are true and complete. I understand and agree ~~that~~ this ~~amendment~~Amendment, together with my ~~Application For Insurance (Part I; Part II – Medical) and any supplement to the~~conversion application, ~~if required, shall constitute~~constitutes the entire application and will be the basis of and become part of any ~~Policy~~policy issued. I ~~understand~~acknowledge that TIAA-CREF Life Insurance Company will rely upon the information provided herein, and that ~~such~~the statements and answers I have provided are given to TIAA-CREF Life Insurance Company ~~to consider~~as consideration for issuing the insurance for which I have applied ~~for. The insurance applied for will not take effect unless and until, during the lifetime of the proposed insured, TIAA-CREF Life Insurance Company has both: (a) received the full first premium payment; and (b) approved the insurance applied for (TIAA-CREF Life Insurance Company will notify you in writing of the approval date).~~.

_____ ~~Date:~~

Signature of ~~Proposed~~ Insured ~~Month Day Year~~ Date

Signature of Owner/Trustee/Corporate Officer/Authorized Party Date

Signature of Collateral Assignee (if applicable) Date

Signature of Irrevocable Beneficiary (if ~~other than Proposed Insured)~~ ~~[XXXXXXX]~~applicable) Date

~~[XXXXXXX]~~

~~TCLF9764~~

Additional Signature(s) - If needed, attach a separate signed and dated copy of this page.

TIAA-CREF Life Insurance Company

READABILITY CERTIFICATION

I, Barry Corday, a duly authorized officer of TIAA-CREF Life Insurance Company hereby certify that the attached application forms identified below meet the minimum reading ease test score on the test used.

Date: February 12, 2020

Barry Corday
Director, Product Management
TIAA-CREF Life Insurance Company

Application Form Number:	Readability Score:
TCL-F9764.1	46.1
F10700.4	49.7